STATE OF MAINE

OCCUPATIONAL THERAPY PRACTICE

APPLICATION FOR LICENSURE

- Permanent Occupational Therapy Assistant

Department of Professional and Financial Regulation
Office of Licensing and Registration
35 State House Station
Augusta, ME 04333-0035

Office Telephone: (207) 624-8626
Office Facsimile: (207) 624-8637
TTY/HEARING IMPAIRED (888) 577-6690
Email: jennifer.l.mooney@maine.gov

Office located at: 122 Northern Avenue, Gardiner, Maine

Revised 2/2006

APPLICATION GUIDE

I. REQUIREMENTS FOR PERMANENT LICENSURE- OCCUPATIONAL THERAPY ASSISTANT

Applicants for permanent licensure must submit:

☐ Application with all sections completed;

☐ Fees: All Checks/Money Orders should be made payable to the "Treasurer, State of Maine". If paying using a credit card please use the Credit Card form at the end of the application. All Fees can be in one payment;

- **$60.00** Application Fee
- **$70.00** License Fee for Occupational Therapy Assistants
- **$15.00** Criminal History Records Check Fee

☐ Two professional references addressing ethical practice– See board Reference Forms;

☐ A completed supervisor's affidavit**;

☐ Verification of licensure from sending state (if applicable); and

☐ Verification of certification form completed and signed by NBCOT. (Form is available at http://www.nbcot.org/verification_orderform)

II. LICENSE TERMS

Licenses are issued for a two-year period and are renewable biennially on March 31st of every odd numbered year.

****Please note: the Board must be notified of any change in the temporary licensee's supervisor within 15 days. Such notification shall be in the form of a signed supervisor's affidavit form and mailed directly to the board. Please refer to Board Rule Chapter 5, Section (3)(4)(B)**

Applications will not be processed until all documentation is received. It is the responsibility of the applicant to see that all documentation is completed and returned to the board for consideration. If you need any further information please contact Jennifer Mooney at (207) 624-8626 or email at jennifer.l.mooney@maine.gov

JOHN ELIAS BALDACCI
GOVERNOR

STATE OF MAINE
DEPARTMENT OF PROFESSIONAL
AND FINANCIAL REGULATION
Board of Occupational Therapy Practice
35 STATE HOUSE STATION
AUGUSTA, MAINE
04333-0035

ANNE L. HEAD
DIRECTOR

Office Use Only		
License # _____		
Cash # _____		
Check # _____		
4440	1422	$70
4440	1446	$60
4440	2619	$15

APPLICATION FOR PERMANENT OCCUPATIONAL THERAPY ASSISTANT LICENSURE

Notice regarding Social Security Number Disclosure

The following statement is made pursuant to the Privacy Act of 1974 section 7 (B). Disclosure of your social security number is mandatory. Solicitation of your social security number is solely for tax administration purposes pursuant to 36 MRSA section 175 as authorized by the Tax Reform Act of 1976 (42 USC section-405 (C) (2) (1)). Your social security number will be disclosed to the State Tax Assessor or an authorized agent for use in determining filing obligations and tax liability pursuant to Title 36 of the Maine Revised Statutes. No further use will be made of your social security number and it shall be treated as confidential tax information pursuant to 36 MRSA section 191.

Notice regarding Public Information

This application is a public record for purposes of Maine's Freedom of Access Law, 1 MRSA §401, et seq. Public records must be made available to any person upon request. Information that you supply as part of this application (except your Social Security number) is public information. Other licensing records to which this information may later be transferred are also considered public records. Where permitted by law, your name, license number, mailing address and other information listed on this application may be posted on the State's website.

Name: _____
First Middle Last Maiden

Any other names used: _____

Address: _____
Street or PO Box County

_____
City/town State Zip code

Home phone number: _____Work phone number: _____

Date of birth: _____Social Security #: _____

NBCOT certification number (n/a for temporary licenses): _____

Examination date: _____

Current or intended place of employment:

_____

Name Street address

_____

City/town State Zip code Telephone #

Employment: reflecting occupational therapy practice for the last three years or two jobs:

Facility Address Position Dates__

_____

_____

Have you ever been licensed in another state or territory? ❒ Yes ❒ No

State: _____ License#: _____

Date Issued: _____ Expiration Date: _____

Has any state board governing the practice of occupational therapy denied your application for examination or licensure?

☐ Yes ☐ No

If yes, please attach explanation.

Has your license ever been suspended or revoked by any state?

☐ Yes ☐ No

If yes, please attach explanation.

CRIMINAL HISTORY RECORDS CHECK PROCEDURE

Pursuant to 5 M.R.S.A. §5301-5303, the State of Maine is granted the authority to take into consideration an applicant's criminal history record. The Office of Licensing and Registration requires a criminal history records check as part of the application process for all applicants.

Have you ever been convicted of a crime other than a minor traffic violation?

☐ Yes ☐ No

If yes, please describe in detail the date(s), crime(s) and submit a copy of the court judgment(s) as well as a letter from you explaining the circumstances surrounding your conviction.

I have read and completed this application and I attest that all the information is true to the best of my knowledge.

Applicant's signature: _____Date: _____

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VERIFICATION OF LICENSURE IN OTHER STATE

DIRECTIONS TO APPLICANT:

Complete front portion of form and forward one to each state where you hold or have held a license to practice occupational therapy.

To: _____ I am applying for a license in the State of
State Board

Maine to practice as a _____. I was granted license # _____

license type _____ on _____ by the State of _____.

The Maine Board of Occupational Therapy Practice requests that I submit verification that my license in the State of _____ is in good standing.

You are hereby authorized to release any information in your files, favorable or otherwise, directly to the Maine Board of Occupational Therapy Practice. Your early attention is appreciated.

Signature: _____

Print Name: _____

Date: _____

Note: Because some States charge a fee to complete this form, you should check with each State before mailing.

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(To be completed by State)

DIRECTIONS TO STATE BOARD: Please complete and return form to the following address:
MAINE BOARD OF OCCUPATIONAL THERAPY PRACTICE
#35 STATE HOUSE STATION
AUGUSTA, MAINE 04333-0035

Name of Licensee: _____ License Type: _____

License #: _____ Date Issued: _____

License Current: Yes _____ No _____ Expiration Date: _____

Name of Exam Taken: _____ Date Exam Passed: _____

If no exam was taken, how was license obtained?

1. Grandfathered: _____ 2. Endorsement/Comity: _____ State: _____

What were the requirements for education at the time the license was issued?

_____

_____

Are there any pending complaints against this licensee?

Yes _____ No _____

Have there been any other actions taken against this licensee?

Yes _____ No _____

Explanation of above if answer is yes: _____

_____

_____

Signature and Title: _____

State Seal

Date: _____

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AUTHORIZATION OF CREDIT CARD PAYMENT

Fees owed to this Department may be paid by the use of a credit card. If you wish to pay your fee(s) with your credit card, please complete this form and send it with your application. Payment through credit cards will not be processed without this authorization form.

Name: **(applicant fees being paid for)**		
***Mailing Address*:** **(applicant fees being paid for)**		
City:	***State:***	***Zip Code:***
County:	***Telephone #: (_____)_____-_____***	
Name of cardholder: **(if other than applicant)**		
***Mailing Address*:** **(if other than applicant)**		
City:	***State:***	***Zip Code:***

I authorize the State of Maine, Department of Professional and Financial Regulation, Office of Licensing and Registration to charge my:

☐ **Visa** ☐ **MasterCard** _____
Card number

Expiration date: _____/_____/_____ in the amount of: $_____

Signature: _____ Date: _____/_____/_____

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REFERENCE FORM

Name of applicant _____

In what professional capacity do you know the applicant? _____

How long have you known the applicant? _____

*Are you related to the applicant? If so, how*_____

Please give a brief statement of your knowledge of the applicant's ethical practice of occupational therapy:

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Date: _____*Signed:* _____

Printed name and title of reference: _____

Mailing address: _____

_____

Telephone number during work hours: _____

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SUPERVISOR'S AFFIDAVIT

(Board requires an updated form for a change in Supervisor ***or level of supervision*** within **15** days of the change)

Please provide a separate form for each place of employment

SECTION A (Completed by the Supervisor)

I, _____assume supervisory responsibility for
(Print Supervisor's Name)

_____ _____Temporary Occupational Therapist or Occupational Therapy Asst.
(Print Name)

***I will provide supervision at the following level, as defined in the Rules of Occupational Therapy**

Practice: ___ ***Direct*** ___ ***Close*** ___ ***Routine*** ___ ***General***

I will immediately notify the Board of Occupational Therapy Practice of any change in supervision of this person.

Date: _____ _____
Supervisor's Signature License No.

_____ _____
Telephone Number Place of Employment

SECTION B (Completed by the Supervisee)

I, _____assume supervision from_____.
(Print Supervisee Name) (Print Supervisor's Name/Licensed OTR)

I will immediately notify the Board of Occupational Therapy Practice of any change in my supervisor.

Date: _____ _____ _____
Supervisee's Signature Place of Employment

** Board of Occupational Therapy Practice rules are available at www.maineprofessionalreg.org